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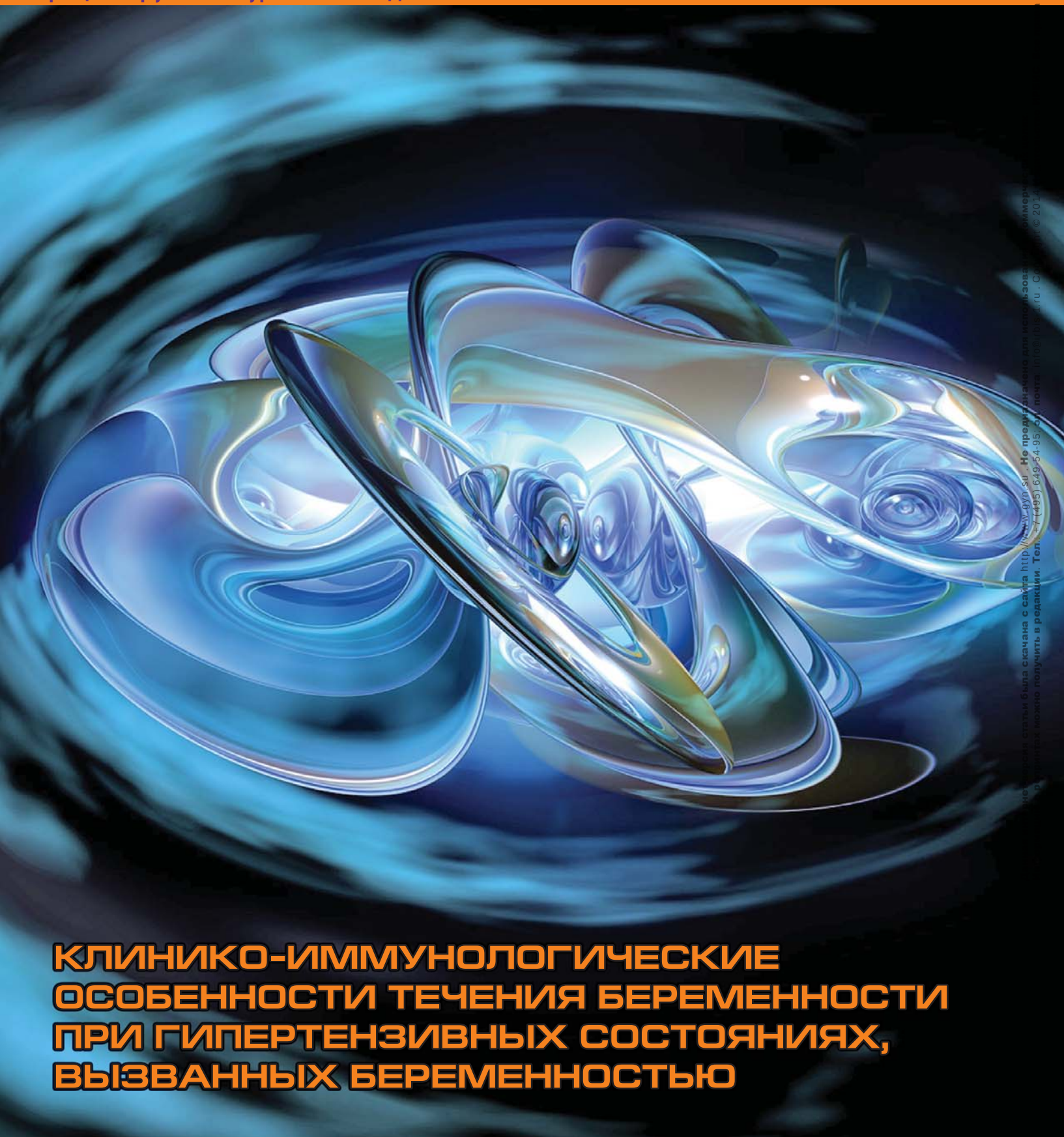

КЛИНИКО-ИММУНОЛОГИЧЕСКИЕ ОСОБЕННОСТИ ТЕЧЕНИЯ БЕРЕМЕННОСТИ ПРИ ГИПЕРТЕНЗИВНЫХ СОСТОЯНИЯХ, ВЫЗВАННЫХ БЕРЕМЕННОСТЬЮ

ETHICS IN OBSTETRIC PRACTICE

Chervenak F.A.[1], McCullough L.B.[2]

[1] *Department of Obstetrics and Gynecology, Weill Medical College of Cornell University (New York, USA)*

[2] *Center for Medical Ethics and Heath Policy, Baylor College of Medicine (Houston, USA)*

Abstract: ethics is an essential dimension of obstetric practice. There is defined medical ethics and the fundamental ethical principles of beneficence and respect for autonomy. We then show how these two principles should interact in obstetric judgment and practice with emphasis on the core concept of the foetus as a patient. We then describe the professional responsibility of obstetric ethics. Obstetricians have beneficence based and autonomy-based obligations to the pregnant patient and beneficence-based obligations to the foetal patient.The result is evidence-based clinical judgement about diagnostic and therapeutic measures that are reliably expected to result in a greater balance of clinical goods over clinical harms. The pregnant woman's autonomy is empowered by offering or recommending medically reasonable alternatives. The informed consent process should be used as a preventive ethics tool.

Key words: obstetrics; ethics; professional responsibility model; informed consent.

Introduction

Ethics is an essential component of obstetric practice. Based on our previous work, we present the professional responsibility model of obstetric ethics [5]. We will emphasise a preventive ethics approach [16]. Preventive ethics aims to prevent ethical conflict in clinical practice by using the informed consent process to present medically reasonable alternatives to the pregnant woman for the management of her pregnancy and to identify and address m advance potential disagreement between the obstetrician and the pregnant woman. The professional responsibility model of obstetric ethics grounds and guides this preventive ethics approach.

Professional Responsibility Model of Obstetric Ethics

We begin by providing a succinct account of the tools of ethical reasoning. We define ethics, medical ethics and the fundamental ethical principles of beneficence and respect for autonomy. We then show how these two principles should interact in obstetric judgment and practice with emphasis on the core concept of the foetus as a patient We then describe the professional responsibility of obstetric ethics.

Ethics has been understood for centuries to be the disciplined study of morality. Morality concerns both right and wrong behaviour and good and bad character. Professional medical ethics is the disciplined study of morality in medicine and identifies the obligations of physicians to patients [16]. Medical ethics should not be confused with the many sources of morality in modern societies. These include, but are not limited to, law, the world's religions, ethnic and cultural traditions, families and personal experience. Professional medical ethics seeks to bridge these cultural differences and identify the obligations of physicians to their patients in all global cultures and national settings.

The first step in doing so is to recognise that professional medical ethics is secular. This understanding of professional medical ethics emerged in the 18m century European and American Enlightenments [9]. Secular professional medical ethics makes no reference to deity or deities or to revealed tradition, but to what reasoned, evidence-based discourse requires and produces. At the same time, secular professional medical ethics is not intrinsically hostile to religious beliefs. Therefore, the ethical principles and virtues of professional medical ethics should be understood to apply to all physicians, regardless of their personal religious and spiritual beliefs and regardless of their nationality or place of practice [16].

The traditions and practices of medicine constitute an obvious source of morality for physicians and therefore provide an important reference point for professional medical ethics because they are based on the obligation to protect and promote the health-related interests of the patient This obligation tells physicians what morality in medicine ought to be, but only in very general, abstract terms. Providing a clinically applicable account of that obligation is in clinical practice the central task of professional medical ethics, using ethical principles. Two ethical principles play a central role in professional medical ethics.

The first is the ethical principle of beneficence. In ethical reasoning generally, the principle of beneficence requires one to act in a way that is reliably expected to produce a greater balance of benefits over harms in the

lives of others. Professional medical ethics specifies this ethical principle to clinical practice: beneficence requires the physician to seek a greater balance of clinical goods over clinical harms in the lives of patients [16]. The task of beneficence-based clinical judgement is to reach reasoned judgements about the appropriate balance of clinical goods and harms when not all of them can be achieved in a particular clinical situation, such as a request for an elective caesarean delivery.

Beneficence-based clinical judgement has an ancient pedigree. Its first expression in the history of Western medical ethics occurs in the Hippocratic Oath and accompanying texts [18]. These texts make an important claim: to interpret reliably the health related interests of the patient from medicine's perspective. This perspective is provided by accumulated scientific research, clinical experience and reasoned responses to uncertainty. As rigorously evidence-based, beneficence-based clinical judgment is not based on the idiosyncratic judgment of the physician, that is, merely on clinical impression or intuition. On the basis of this rigorous clinical perspective, focused on the best available evidence, beneficence-based clinical judgment identifies the clinical benefits that can be achieved for the patient based on the competencies of medicine. The clinical benefits that medicine is competent to seek for patients are the prevention and management of disease, injury, disability, lost functional status and unnecessary pain and suffering, and the prevention of premature or unnecessary death. Pain and suffering become unnecessary when they do not result in achieving the other goods of clinical care, for example, allowing a woman to labour without effective analgesia [16].

The ethical principle of non-maleficence requires the physician not to cause harm and is best understood as expressing the limits of beneficence- based clinical judgement. This ethical principle is also known as Primum non nocere or "first do no harm." This commonly invoked dogma is really a Latinised misinterpretation of the Hippocratic texts, which emphasised beneficence while avoiding harm when approaching the limits of medicine to maintain or improve the patient's condition or to alter the course of disease or injury [2,16]. Non-maleficence should be incorporated into beneficence-based clinical judgement: when the physician approaches the limits of beneficence-based clinical judgement, that is, when the evidence for expected clinical benefit diminishes and the risks of clinical harm increases, then the physician should proceed with great caution. The physician should be especially concerned in such clinical circumstances to prevent serious, far-reaching and irreversible clinical harm to the patient.

It is important to appreciate that there is an inherent risk of paternalism in beneficence-based clinical judgement. By this we mean that beneficence- based clinical judgement, if it is mistakenly considered to be the sole source of professional responsibility and therefore moral authority in obstetrical care, invites the unwary obstetrician to conclude that beneficence-based judgements can simply be imposed on the pregnant woman in violation of her autonomy. Paternalism can become dehumanising treatment of the pregnant woman and, therefore, should be avoided in obstetric practice.

The antidote to paternalism is respect for the pregnant woman's autonomy. This ethical principle requires the physician to empower the pregnant woman to make informed decisions about the management of her pregnancy. The most important way that physicians fulfil this obligation is to identify medically reasonable alternatives to the pregnant woman and to identify alternatives that, while technically possible, are not reliably judged to be medically reasonable. "Medically reasonable" means that there is a beneficence-based clinical judgement that a form of clinical management or intervention has a reliable evidence base for expected net clinical benefit. There is no ethical obligation to offer a technically possible alternative that does not meet this test for being medically reasonable. When this is met, the alternative should be offered, along with all other medically reasonable alternatives. Sometimes the evidence clearly supports one alternative as clinically superior to others or as the only medically reasonable alternative. In such clinical circumstances, the physician should recommend this alternative to the pregnant woman. Sometimes the evidence clearly supports an alternative as not medically reasonable. In such clinical circumstances, the physician should not offer this alternative to the pregnant woman. Sometimes the evidence clearly supports an alternative as not only not medically reasonable but on balance clinically harmful. In such clinical circumstances, the physician should recommend against this clinical alternative and not perform it.

Patients exercise their capacity for autonomous decision-making in response to alternatives that are offered or recommended by the physician in the informed consent process. The capacity for autonomous decision-making has three components: (1) absorbing and retaining information about her condition and the medically reasonable diagnostic and therapeutic responses to it; (2) understanding that information, that is, evaluating and rank-ordering those responses and appreciating that she could experience the risks of treatment; and (3) expressing a value-based authorisation, or refusal of authorisation, of offered or recommended clinical management. The physician has a role to play in each of these. They are, respectively, as follows: (1) to recognise the capacity of each patient to deal with medical information and not to underestimate that capacity, provide information (i.e. disclose and explain all medically reasonable alternatives) and recognise the validity of the values and beliefs of the patient; (2) not to interfere with but, when necessary, to assist the patient in her evaluation and ranking of the medically reasonable diagnostic and therapeutic alternatives for managing her condition; and (3) to elicit and implement the patient's value-based authorisation or refusal of authorization [19].

The common law in the United States played an important role in clarifying the physician's obligation to provide

information to the patient to empower her to make informed decisions. Two major contributions were made in the twentieth century: the concepts of simple and informed consent. The concept of simple consent was established in a landmark gynaecological case, Schloendorff v. The Society of The New York Hospital. Simple consent concerns whether the patient says "yes" or "no" to medical intervention [10,19]. To this day in the medical and bioethics literature, this decision is quoted as follows: "Every human being of adult years and sound mind has the right to determine what shall be done with his body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages" [8].

The concept of informed consent further evolved to include disclosure of information sufficient to enable patients to make informed decisions about whether to say "yes," informed authorisation, or "no," informed refusal, to medical intervention [10]. Two accepted legal standards emerged. The professional community standard defines adequate disclosure in the context of what relevantly trained and experienced physicians actually tell patients. The reasonable person standard, which has been adopted by most states in the United States (where the states regulate the practice of medicine, not the federal government), goes further and requires the physician to disclose "material information." This phrase means information that any patient in a particular patient's condition needs to know and that the lay person of average sophistication should not be expected to know. Patients need to know that what the physician thinks is clinically salient, i.e., the physician's beneficence- based clinical judgement about medically reasonable alternatives: what they involve and their clinical benefits and risks. The reasonable person standard has emerged as the accepted ethical standard. [10,16]. We, therefore, adopt it in this chapter. On this standard, the physician should disclose to the pregnant patient her or the foetus's diagnosis (including differential diagnosis when that is all that is known), the medically reasonable alternatives to diagnose and manage the patient's condition, the short-term and long-term clinical benefits and risks of each alternative and the evidence-based, deliberative judgement of the physician that the clinical benefits outweigh the clinical harms.

Respect for autonomy does not require the physician to implement a patient's preference simply on the basis that the patient has freely expressed it. Put another way, the exercise of rights by the patient should not be regarded as an absolute determinant of the physician's clinical practice [2,16].

The ethical principles of beneficence and respect for autonomy should guide professional obstetric clinical judgement and practice. There are beneficence-based and autonomy-based obligations to the pregnant patient: the physician's perspective on the pregnant woman's health-related interests provides the basis for the physician's beneficence-based obligations to her, whereas her own perspective on those interests provides the basis for the physician's autonomy-based obligations to her, as described above. Because of an insufficiently developed central nervous system, the foetus cannot meaningfully be said to possess values and beliefs. Thus, there is no basis for saying that a foetus has a perspective on its interests. Therefore, there can be no autonomy-based obligations to any foetus. Obviously, the physician has .1 perspective on the foetus's health-related interests, and the physician «.in have beneficence-based obligations to the foetus, but only when the foetus is a patient. Because of its importance for obstetric clinical judgement and practice, the ethical concept of the foetus as a patient requires detailed consideration [16].

Developments in foetal diagnosis and management strategies to optimise foetal outcome have become widely accepted, encouraging the development of the ethical concept of the foetus as a patient. This concept has considerable clinical significance because when the foetus is a patient, directive counselling (i.e. recommending a form of management for foetal benefit) is appropriate, and when the foetus is not a patient, non-directive counselling (i.e. offering but not recommending a form of management for foetal benefit) is appropriate [16].

One prominent approach for establishing whether or not the foetus is a patient attempts toshow whether or notthefoetus has independent moral status. "Independent moral status" for the foetus means that one or more characteristics that the foetus possesses in and of itself and, therefore, independently of the pregnant woman or any other factor, generate and therefore ground obligations to the foetus on the part of the pregnant woman and her physician. Many foetal characteristics have been nominated for this role, including moment of conception, implantation, central nervous system development, quickening and the moment of birth. It should come as no surprise that there is considerable variation among ethical arguments about when the foetus acquires independent moral status. One view is that the foetus has independent moral status from the moment of conception or implantation. Another view is that independent moral status is acquired in degrees, thus resulting in "graded" moral status. Still another view holds, at least by implication, that the foetus never has independent moral status so long as it is in utero [1,4].

Despite a centuries-old, global and an ever-expanding theological and philosophical literature on this subject, there has been no closure on a single authoritative account of the independent moral status of the foetus. Given the absence of a single method that would be authoritative for all of the markedly diverse theological and philosophical schools of thought involved in this endless debate, closure is impossible. All attempts to explain the ethical concept on the basis of the purported independent moral status of the foetus are irresolvably controversial and thus provide no reliable clinical basis for the application of the concept.

A clinically reliable explanation of the ethical concept of the foetus as a patient starts with the recognition that being a patient does not require that one possesses independent moral status. The ethical concept of being a

patient is clinically straightforward: a human being (1) is presented to a physician (or other healthcare professional) and (2) there exist clinical interventions that are reliably expected to be efficacious, in that they are reliably expected to result in a greater balance of clinical benefits over harms for the human being in question/ In the technical language of normative ethics this is known as the dependent moral status of the foetus.

The authors have argued elsewhere that beneficence-based obligations to the foetus exist when the foetus is reliably expected later to achieve independent moral status as a child and person [16]. That is, the foetus is a patient when the foetus is presented for medical interventions, whether diagnostic or therapeutic, that reasonably can be expected to result in a greater balance of goods over harms for the child and person the foetus can later become during early childhood. The ethical significance of the concept of the foetus as a patient, therefore, depends on links that can be established between the foetus and its later achieving independent moral status.

One such link is viability. Viability, however, must be understood in terms of both biological and technological factors. It is only by virtue of both factors that a viable foetus can exist ex utero and thus achieve independent moral status. When a foetus is viable, that is, when it is of sufficient maturity so that it can survive into the neonatal period and can achieve independent moral status given the availability of the requisite technological support, and when it is presented to the physician, the foetus is a patient.

Viability exists as a function of biomedical and technological capacities, which are different in different parts of the world. As a consequence, there is, at the present time, no worldwide, uniform gestational age to define viability. In the United States, we believe that viability presently occurs at approximately 24 weeks of gestational age [3,6].

Before viability the only link between the foetus and its later becoming a child is the pregnant woman's decision to continue her pregnancy to viability. The previable foetus is, therefore, a patient solely as a function of the pregnant woman's autonomous decision to confer this moral status on her foetus(es) [16].

When the foetus is a patient, directive counselling for foetal benefit is ethically justified. In clinical practice, directive counselling for foetal benefit involves one or more of the following: recommending against termination of pregnancy; recommending against non-aggressive management; or recommending aggressive management. Aggressive obstetric management includes interventions such as foetal surveillance, tocolysis, caesarean delivery or delivery in a tertiary care centre when indicated.

Non-aggressive obstetric management excludes such interventions. Directive counselling for foetal benefit, however, must take account of the presence and severity of foetal anomalies, extreme prematurity and obligations to the pregnant woman.

Directive counselling for foetal benefit must occur in the context of balancing beneficence-based obligations to the foetus against beneficence- and autonomy-based obligations to the pregnant woman. Such balancing must recognise that a pregnant woman is obligated only to take reasonable risks of medical interventions that are reliably expected to benefit the viable foetus or child later.

Obviously, any strategy for directive counselling for foetal benefit that takes account of obligations to the pregnant woman must be open to the possibility of conflict between the physician's recommendation and a pregnant woman's autonomous decision to the contrary. Such conflict is best managed preventively by preventive ethics: the use of the informed consent process as an ongoing dialogue throughout a woman's pregnancy, augmented as necessary by negotiation and respectful persuasion [16].

This approach to obstetric ethics is known as the professional responsibility model of obstetric ethics [5]. This model provides an antidote to the rights-based reductionism that characterises much of the literature on obstetric ethics. This over-simplification of obstetric ethics occurs when the only or over-riding ethical consideration is rights of either the pregnant woman or the foetus.

Right-based reductionism is best illustrated by the abortion controversy. One extreme asserts that foetal rights always over-ride the rights of the pregnant woman. This is foetal-rights reductionism. Termination of pregnancy at any gestational age or for any reason is impermissible, regardless of whether the pregnancy is voluntary or not or viable or not. The other extreme asserts that the pregnant woman's rights always over-ride foetal rights. This is woman's rights reductionism. Termination of pregnancy is, therefore, permissible at any gestational age and for any or many reasons [12].

Such rights talk is initially appealing because of the simple dichotomy at its heart: one either has rights or one does not and, if one does, others must respect one's rights. This simple dichotomy is simplistic and does not withstand close clinical ethical scrutiny. There is unavoidable controversy about the nature and limits of both foetal and women's rights. Such rights are based on many factors, including cultural, political and religious beliefs that do not lend themselves to compromise and are outside of the physician-patient relationship.

Consider the simplistic claim that a pregnant woman has unconditional right to control what happens to her body. The claim ignores a fundamental question: should this right be understood to come with limits or with no exceptions throughout the entire pregnancy? Professional integrity sets justified limits on the preferences of pregnant women [16]. For example, a distraught woman who is 34 weeks pregnant reports that her husband has deserted her and insists on induced abortion immediately. The professional responsibility model requires her obstetrician not to implement her request because foeticide is ruled out by the obstetrician's beneficence-based obligation to protect the life of this foetal patient. The obstetrician should, therefore, recommend against foeticide and explain that no conscientious obstetrician should implement her request.

There are many such circumstances in which a pregnant woman's request for an induced abortion should not be implemented unquestioningly.

Consider the simplistic claim that the foetus has an unconditional right to life or to complete gestation. The presence of a foetal anomaly incompatible with life belies such claims as lacking scientific and clinical foundation, because medicine has no capacity to correct such anomalies. Such claims lack an authoritative foundation in either religion or philosophy [16]. There is no single authoritative perspective from which the incompatible differences of these diverse views on foetal rights can be resolved [16]. To insist on an unconditional right to life or to complete gestation, therefore, has no place in professional obstetric ethics.

The woman's-rights reductionism approach appears in the literature on intrapartum management. This approach asserts an unconditional right of the pregnant woman to control her body in all aspects of the management of pregnancy, including the performance of caesarean delivery: "... the moral and legal primacy of the competent, informed pregnant woman in decision making is overwhelming" [1]. Another expression of this approach at first seems to be non- reductionist. Its authors acknowledge patient safety as a "first-order issue" [13] and support what they call "restrictive guidelines" based on protecting the life and health of pregnant women [13]. This more nuanced approach, however, is abandoned in favour of the woman's-rights reductionism model when it is asserted: "Crucially, even when restrictive guidelines are warranted the rights of pregnant women to bodily integrity must be maintained" [14]. Some express this approach explicitly, for example, that "women have fully endowed rights that do not diminish with conception, nor progressively degrade as pregnancy advances to viability and birth"[14]. The woman's-rights reductionism approach has been used to claim the right of pregnant women to have a clinically non- indicated caesarean delivery [3,11]. Another example is the assertion of the pregnant woman's autonomy as an "unrestricted negative right," that is, an unconditional right to non-interference with refusal of caesarean delivery: "autonomy is an inter-relational right– ultimately there is no circumstance in which someone should be brought to an operating room against their will" [15].

Rights-based reductionism in obstetric ethics is a fallacy, because it unacceptably distorts the professional nature of the relationship of an obstetrician to his or her patients. The professional obligations of the obstetrician originate in the ethical concept of medicine as a profession. This concept was introduced into the history of medicine by Dr. John Gregory (1740-1773) of Scotland and Dr. Thomas Percival (1740-1804) of England. This concept requires the physician to make three commitments: (1) becoming and remaining scientifically and clinically competent; (2) protecting and promoting the health-related and other interests of the patient as the physician's primary concern and motivation; and (3) preserving and strengthening medicine as what Percival called a "public trust," a social institution that exists primarily for the benefit of society not its members (in contrast to the concept of medicine as a merchant guild) [17].

In the professional responsibility model, obstetricians have beneficence based and autonomy-based obligations to the pregnant patient and beneficence-based obligations to the foetal patient [8,16]. The result is evidence- based clinical judgement about diagnostic and therapeutic measures that are reliably expected to result in a greater balance of clinical goods over clinical harms. The pregnant woman's autonomy is empowered by offering or recommending medically reasonable alternatives, as explained above.

The contrast with rights-based reductionism is stark. Foetal rights – reductionism, despite its simplicity and powerful initial appeal, is fallacious because it leads obstetric ethics into conceptual and clinical failure. Therefore this model should be abandoned. Woman's-rights reductionism is a failure as well and requires the obstetrician to implement birth plans that unconditionally exclude caesarean delivery or the unconditional right to planned home birth. This model eliminates the obstetrician's beneficence-based obligations to both the pregnant and foetal patients and therefore reduces the obstetrician to a mere automaton. This model also has absurd implications, for example, ruling out, as potential paternalism, strongly and repeatedly recommending that pregnant women who abuse tobacco and alcohol seek help and be supported in doing so. Respect for the pregnant woman's rights allows simply accepting such clinically choices by patients because they have made clinically unwise, but autonomous, choices. This is abandonment from the perspective of professional responsibility for patients. The woman's-rights reductionism model, despite its simplicity and powerful appeal for many, is fallacious because it leads obstetric ethics to conceptual and clinical failure. This model, therefore, also should be abandoned.

Conclusion

Ethics is an essential dimension of obstetric practice. The professional responsibility of obstetric ethics, which we have described above, is based on the pioneering medical ethics of two major figures in its history - Dr. John Gregory and Dr. Thomas Percival. The ethical concept of medicine as a profession introduced into the history of medical ethics in the 18th century by these two remarkable physician-ethicists has proven to be both durable and clinically applicable today. The professional responsibility model of obstetric ethics protects clinical judgement and practice from the simplistic, clinically inadequate alternatives of maternal rights-based reductionism and foetal rights-based reductionism. The professional responsibility model does so by requiring in all cases deliberative consideration of beneficence-based and autonomy-based obligations to the pregnant patient and beneficence-based obligations to the foetal patient. The informed consent process should be used as a preventive ethics tool to empower pregnant women to make informed and deliberative decisions.

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ЭТИКА В АКУШЕРСКОЙ ПРАКТИКЕ

Червенак Ф.А.[1], МакКуллоу Л.Б.[2]

[1] Департамент Акушерства и Гинекологии. Медицинский Колледж Вейл Корнелльского Университета (Нью-Йорк, США)

[2] Центр Медицинской Этики и Охраны здоровья. Колледж Медицины Бэйлор (Хьюстон, США)

Резюме: этика является важным аспектом в акушерской практике. В рамках публикации дано определение медицинской этики, приведены фундаментальные этические принципы милосердия и уважения личности. Авторы раскрывают сущность взаимодействия этих принципов с акушерскими воззрениями и практическими подходами с фокусом на концепции, рассматривающей плод в качестве пациента. В работе описана профессиональная ответственность в плоскости этики в акушерстве. В своей работе акушеры должны основываться на милосердии и личностном подходе к беременной женщине, а также на обязательствах милосердия к плоду, как к пациенту. Результатом являются клинические суждения на основе фактических данных диагностических и лечебных мероприятий. Это должно сместить баланс клинической пользы и вреда в лучшую сторону. Беременная женщина имеет право получить рекомендованные, с медицинской точки зрения, разумные альтернативы. В качестве превентивного этического инструмента должно использоваться информированное согласие.

Ключевые слова: акушерство, этика, профессиональная модель ответственности, информированное согласие.